STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

LIMITED MARKET CONDUCT EXAMINATION

AND

LIMITED SCOPE COMPLIANCE EXAMINATION

OF

JOHN DEERE HEALTH PLAN, INC.

MOLINE, ILLINOIS

FOR THE PERIOD JANUARY 1, 2003,
THROUGH DECEMBER 31, 2003

TABLE OF CONTENTS

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DATE: March 29, 2005

The examination fieldwork for a limited market conduct examination of claims processing and limited scope compliance examination at John Deere Health Plan, Inc., 1300 River Drive, Moline, Illinois, was completed August 13, 2004. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of John Deere Health Plan, Inc. (JDHP). This report also reflects the results of a compliance examination of JDHP's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of JDHP was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement between the State of Tennessee and JDHP, Executive Order No. 1 dated January 26, 1995, and §§ 56-32-215 and 56-32-232 of the Tennessee Code Annotated (Tenn. Code Ann.).

JDHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

During 2004, the State of Illinois, Department of Insurance conducted a full scope financial examination of John Deere Health Plan, Inc. The Tennessee Department of Commerce and Insurance received and accepted Illinois' Report of Examination dated March 22, 2004. As a result, this division did not conduct a financial examination of John Deere Health Plan, Inc. as part of this examination.

The market conduct examination focused on the claims processing functions and performance of JDHP. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope compliance examination focused on JDHP's provider appeals procedures, provider agreements and subcontracts, compliance with certain terms of the Contractor Risk Agreement, and JDHP's demonstration of compliance with Federal Title VI of the 1964 Civil Rights Act.

Fieldwork was performed using records provided by JDHP before and during the onsite examination from July 27, 2004, through August 13, 2004.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that JDHP's operations were administered in accordance with the Contractor Risk Agreement and state statutes and regulations concerning HMO operations, thus reasonably assuring that JDHP's TennCare members received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether JDHP met its contractual obligations under the Contractor Risk Agreement and whether JDHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq.*;

- Determine whether JDHP properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether JDHP had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether JDHP had corrected deficiencies outlined in the prior examination conducted by TDCI.

III. PROFILE

A. Administrative Organization of JDHP

Heritage National Healthplan, Inc. (HNHI), an Illinois HMO, was incorporated under the laws of the State of Illinois on August 5, 1985, and was licensed as an HMO by the State of Illinois Department of Insurance in 1985. HNHI was licensed as an HMO by the State of Tennessee Department of Commerce and Insurance on June 20, 1995. HNHI is a wholly-owned subsidiary of John Deere Health Care, Inc., (JDHC) which is a wholly-owned subsidiary of Deere & Company (Deere).

Heritage National Healthplan of Tennessee, Inc. (HNHT), a Tennessee health maintenance organization, was incorporated under the laws of the State of Tennessee on October 25, 1985, and was thereafter licensed as an HMO by the State of Tennessee Department of Commerce and Insurance on

July 1, 1986. Under its license, HNHT administered commercial plans and also participated as a contracted HMO in the TennCare program.

On September 10, 1996, HNHT, submitted to the State of Tennessee Department of Commerce and Insurance a proposed plan to merge with and into HNHI. On November 18, 1996, the merger of HNHT with and into HNHI was approved by the Commissioner of the Tennessee Department of Commerce and Insurance to be effective December 31, 1996. Effective July 1, 1999, HNHI changed its name to John Deere Health Plan, Inc.

The officers and board of directors for JDHP at December 31, 2003, were as follows:

Officers for JDHP

Richard L. Bartash, M.D., President
James A. Cousins, Senior Vice President & Treasurer
Victoria J. Graves, Senior Vice President, & Secretary
Douglas A. Niska, Vice President
Charles P. Parsons, Senior Vice President
Bruce Chase Steffens, M.D., Vice President & Chief Medical Officer
Thomas K. Jarrett, Assistant Secretary
Nathan J. Jones, Assistant Treasurer

Board of Directors for JDHP

William Kenneth Applegate	Richard Lowell Bartash, M.D.
Jon Alan Chapman	James Alan Cousins
John Willard Golden, M.D.	James Edward Hecker
Victoria Kauzlarich	Charlotte Hershberger Koenig, M.D.
Charles Phillip Parsons	Bruce Chase Steffens, M.D.
Cathie Sue Whiteside	

B. Brief Overview

JDHP or its predecessors have participated in the state's TennCare program since the program's inception in January 1994.

JDHP is managed by John Deere Health Care, Inc. ("JDHC"), pursuant to a service agreement. Per this service agreement, all TennCare administrative fees received by JDHP are remitted to JDHC in exchange for all management services.

JDHP is currently authorized by TDCI and the TennCare Bureau to participate in the TennCare program in the Eastern Grand Region. JDHP derives most of its total revenue in the form of premium payments from its

commercial line of business. As of December 31, 2003, JDHP received 20.5% of its 2003 nationwide revenue and 40.0% of its 2003 Tennessee revenues from payments from the State of Tennessee for providing medical benefits to TennCare members. As of December 31, 2003, JDHP had 81,038 TennCare members.

The TennCare Oversight Division of the Department of Commerce and Insurance's responsibility is limited to JDHP's participation in the TennCare program. The Insurance Examination Division of the Department of Commerce and Insurance has primary responsibility for HMOs that obtain less than eighty percent (80%) of their revenue from the TennCare Program. This market conduct examination of JDHP's claims processing system is limited to TennCare claims.

Effective July 1, 2002, the Contractor Risk Agreement with JDHP was amended to temporarily operate under a non-risk agreement. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the Bureau of TennCare in restructuring the program design to better serve Tennesseans adequately and responsibly. JDHP agreed not to make any change to the reimbursement rates, reimbursement policies and procedures, and medical management policies in effect on April 16, 2002, unless such changes received approval in advance by the Bureau of TennCare.

During the stabilization period, JDHP receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to JDHP. The TennCare Bureau reimburses JDHP for the cost of providing covered services to TennCare enrollees.

C. Claims Processing Not Performed by JDHP

During the period under examination, JDHP subcontracted with the following vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- Davis Vision, Inc., for vision services
- Southland Health Services, LLC (formerly Quality Transportation) for transportation services

Because subcontractors processed the claims for these benefits, claims for these services were not included in the pool of JDHP's claims from which claims were selected for testing. Therefore, no vision or transportation claims were tested for compliance with the TennCare Contract and Tenn. Code Ann. § 56-32-226. JDHP has no capitated providers.

Except for timeliness testing of pharmacy claims, pharmacy claims were not otherwise tested as part of the examination. As of July 1, 2003, JDHP was no longer contractually responsible for pharmacy benefits. The TennCare Bureau contracted directly with a single pharmacy benefits manager as of July 1, 2003, for the provision of pharmacy benefits to all TennCare enrollees.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are set forth for informational purposes. The following were claims processing and compliance deficiencies cited in the examination by the Tennessee Department of Commerce and Insurance, TennCare Division, for the period January 1, 2001, through June 30, 2001:

A. Summary of Deficiencies - Claims Processing

1. The denial reason for 1 of 7 properly denied claims was incorrect.

2. For 11 of 53 paid claims reviewed, not enough information was provided to determine if the claim was properly adjudicated. JDHP's pharmacy subcontractor processed these claims.

3. There is no coordination between JDHP's two out-of-pocket accumulators.

4. The information recorded in JDHP's claims system for 5 of the 60 claims tested did not contain all of the required elements.

5. The claim date received in the claims processing system was not always correct.

6. JDHP did not establish immediate control of claims in the mailroom.

Deficiency number 4 is repeated as part of this report. The other deficiencies noted above were corrected and thus not repeated in this report.

B. Summary of Deficiencies - Compliance

1. The weekly claims processing report submitted to the TennCare Bureau was not completed properly.

2. The documentation maintained for provider appeals was inadequate.

3. JDHP's pharmacy provider agreement was not in compliance with the TennCare contract.

4. JDHP's subcontracts were not in compliance with the TennCare contract.

5. JDHP's procedures for monitoring subcontractor claim processing and Title VI compliance with the TennCare contract were inadequate.

6. JDHP did not always pay its subcontractor in a timely manner as required by the subcontract.

Deficiencies number 3, 4 and 6 are repeated as part of this report. The other deficiencies noted above were corrected and thus not repeated in this report.

V. SUMMARY OF CURRENT PERTINENT FACTUAL FINDINGS

The summary of current factual findings is set forth below. The details of testing as well as management's comment to each finding can be found in Sections VI and VII of this examination report.

A. Claims Processing Deficiencies

1. JDHP did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b) for the months of July 2003 through January 2004. (Section VI.A.)

2. The data recorded in JDHP's claims processing system for 2 of the 60 claims tested did not contain all of the required elements of encounter data reporting. (Section VI. E.)

3. Two claims did not pay at the correct rate. (Section VI. G)

B. Compliance Deficiencies

1. JDHP did not always respond to provider complaints within the timeframe dictated in their correspondence with the provider. For nine of the ten provider complaints tested, JDHP did not respond within 45 days with a written notification of a decision as specified in correspondence by JDHP. (See Section VII.A.)

2. The three provider agreements selected for testing did not include all provisions required by Section 2-18. of the Contractor Risk Agreement. (See Section VII.C.2.)

3. Two of the three executed provider agreements tested did not use the current provider template approved by TDCI. (See Section VII.C.2.)

4. Subcontracts for major medical services between JDHP and Davis Vision and JDHP and Quality Transportation were not approved by TDCI prior to execution.
(See Section VII.D)

5. JDHP did not return interest generated from the deposit of state funds held for provider payments as required by Section 2-9.e.5. of the Contractor Risk Agreement.
(See Section VII.H)

VI. DETAIL OF TESTS CONDUCTED

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether JDHP pays claims promptly within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1), and Section 2-18. of the Contractor Risk Agreement. The statute mandates the following prompt pay requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are processed, and if appropriate paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI had previously requested data files from all TennCare MCOs containing all claims processed during the months of January 2003, April 2003, July 2003, and October 2003. Each set of data was tested in its entirety for compliance with the prompt pay requirements of Tenn. Code Ann. Separate files were submitted for medical and pharmacy claim types. Pharmacy claims were submitted only for January 2003, and April 2003, since as of July 1, 2003, the MCOs were no longer contractually responsible for pharmacy benefits. JDHP processed its own pharmacy claims and did not use a subcontractor.

Because JDHP failed to meet prompt pay compliance for the month of July 2003, JDHP was required to submit monthly data files until compliance was achieved in January 2004. Since the testing by TDCI for prompt pay compliance for each month tested is based on all claims processed, no projections of results to the population are needed. Listed below are the results of these analyses:

Medical Results

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2003	98.86%	99.84%	**Yes**
April 2003	91.79%	99.51%	**Yes**
July 2003	78.31%	99.05%	**No**
August 2003	80.81%	98.35%	**No**
September 2003	91.78%	98.86%	**No**
October 2003	93.35%	98.87%	**No**
November 2003	96.90%	98.62%	**No**
December 2003	91.91%	98.97%	**No**
January 2004	89.18%	99.79%	**No**
February 2004	98.78%	99.72%	**Yes**
April 2004	99.16%	99.93%	**Yes**

Pharmacy Results

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2003	100%	100%	**Yes**
April 2003	100%	100%	**Yes**

JDHP did not process claims timely in accordance with Tenn. Code Ann. 56-32-226(b)(1) for the months of July 2003 through January 2004. On March 10, 2004, TDCI levied a $10,000 administrative penalty as a result of JDHP's failure to comply. On March 24, 2004, the Bureau of TennCare, Dept. of Finance and Administration, assessed $60,000 in liquidated damages as a result of JDHP's failure to comply.

In March 2003, JDHP began processing TennCare claims on a new claims processing system. JDHP responded to TDCI's questions regarding JDHP's failure to meet prompt pay requirements by stating that "the reasons are the result of a claims system conversion." The conversion was a factor in JDHP's failure to meet the guidelines for timely claims processing.

Management's Comments

JDHP concurs with the finding. Subsequent to implementation of our new claims processing system JDHP has been compliant with prompt pay requirements each month. The results for the 2004 quarterly audits conducted by TDCI for prompt payment substantiate JDHP's compliance.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of test work to be performed in testing JDHP's claims processing system.

TDCI reviewed the following items to determine the risk that JDHP had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints on file with TDCI related to accurate claims processing
- Results of TDCI's prompt pay testing
- Results reported on the claims payment accuracy report submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims payment accuracy reports
- Review of internal controls

TDCI's review of these systems and controls revealed no significant deficiencies. JDHP attributed its failure to meet the prompt pay requirements of Tenn. Code Ann. § 56-32-226(b) to the claims processing system conversion. Therefore, TDCI did not expand substantive testing.

C. Claims Payment Accuracy Report

Section 2-9. of the Contractor Risk Agreement requires that 97% of claims be paid accurately upon initial submission. JDHP is required to submit a claims payment accuracy report 30 days following the end of each quarter.

JDHP reported the following results for the examination period:

	Claims Tested	Results Reported	Compliance
First Quarter 2003	600	98.61%	**Yes**
Second Quarter 2003	600	98.47%	**Yes**
Third Quarter 2003	600	98.61%	**Yes**
Fourth Quarter 2003	600	97.78%	**Yes**
First Quarter 2004	600	99.79%	**Yes**
Second Quarter 2004	600	99.55%	**Yes**

1. Procedures to Review Claims Payment Accuracy Reporting

The review of the claims processing accuracy report included an interview with staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the second quarter 2004 claims payment accuracy report. This review included verification that the number of claims tested by JDHP constituted a statistically valid sample.

In addition, TDCI and the Comptroller selected claims at random from JDHP's second quarter 2004 claims payment accuracy report. These claims were reviewed to determine if the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation traced directly to the actual report filed with TennCare.

2. Results of Review of the Claims Payment Accuracy Reporting

   The quarterly claims payment accuracy report for the second quarter of 2004 was selected for review. TDCI and the Comptroller judgmentally selected 20 claims for testing that were identified by JDHP as correctly paid. Also, all claims identified in the report with errors were reviewed to ensure the errors had been corrected. No deficiencies were noted in the claims reviewed by TDCI and the Comptroller.

D. Claims Selected For Testing

TDCI and the Comptroller selected 60 claims for testing. From previous prompt pay testing by TDCI, JDHP had provided data files of claims processed for the months of January, April, July, August, September, October, November, and December 2003. For each claim processed, the data file included the date received, date paid, the amount paid and, if applicable, an explanation for denial of payment. From the combined data files, 60 claims were selected using a random number generator.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of non-compliance within the total population of claims.

To ensure that the data files included all claims processed in the month, the total amount paid per each data file was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in the claims processing system. Attachment XII of the Contractor Risk Agreement lists the minimum required data elements to be captured from medical claims and reported to TennCare as encounter data. Original hard copy claims were requested for the 60 claims tested. If the claim was submitted electronically, TDCI requested the original electronic submission file associated with the claim.

The data elements of Attachment XII recorded on the claims selected were compared to the data elements entered into JDHP's claims processing system. Of the 60 claims examined, two claims contained discrepancies between data submitted on the claim and the data entered into JDHP's claims processing system. For both of these claims, only three of four diagnosis codes were entered into JDHP's claims processing system. This is a system limitation because JDHP's claims processing system only accepts a

maximum of three diagnosis codes.

Management's Comments

JDHP concurs with the finding. Due to system limitations not all diagnosis codes were captured in the previous claims processing system. With the conversion to a different processing system, all diagnosis codes are currently captured.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. A review of all 60 claims revealed no deficiencies.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly. Of the 60 claims tested, two pricing errors were discovered.

1. One claim did not pay correctly for one procedure at the rates specified in the contracted fee schedule. The rate per unit was incorrectly loaded in the claims payment system and paid $1.61 per unit when it should have paid $9.02 per unit.

2. One claim did not pay for four procedures at the rates specified in the contracted fee schedule. JDHP agreed to adjust the claim to pay the rate specified in the contracted fee schedule.

Management's Comments

JDHP concurs with the finding. The claims have been adjusted.

H. Withhold and Copayment Testing

The purpose of "withhold testing" is to determine whether amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated.

- JDHP's contracts provide for the sharing of risk through withhold procedures. While JDHP is not at risk, JDHP's providers do not participate in the withhold process. Since this is expected to be a temporary situation and most providers participate in multiple lines of

business, not all the providers' withhold indicators are zero. Ten claims with withholds were selected to determine if the withhold was returned to the provider. All ten withholds were returned to the providers intact.

The purpose of testing copayments is to determine whether enrollees are subject to out-of-pocket payments for certain procedures, within liability limitations, and if out-of-pocket payments are accurately calculated in accordance with Section 2-3.K. of the Contractor Risk Agreement.

- From the 60 claims tested, 10 claims were selected based on the enrollee's eligibility as Uninsured/Uninsurable as reported on the TennCare eligibility system. For all 10 claims tested, the copayment was calculated correctly.

I. Explanation of Benefits ("EOB") Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to deductibles and copayments are provided an explanation of benefits in accordance with usual and customary health care industry practices.

JDHP provides EOBs to all enrollees. JDHP provided copies of the EOB sent for all 60 claims tested. No discrepancies were noted in the information provided on the EOB when compared to information in the claims processing system.

J. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to the provider accurately reflect the processed claim information in the system.

The remittance advices for ten of the 60 claims tested above were requested to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the information communicated to the providers.

K. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to verify the actual payment of claims by JDHP, and determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The cancelled checks for ten claims tested above in remittance advice testing were requested. The check amounts agreed with the amounts paid per the

remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

L. Pended Claims

The purpose of testing pended claims is to determine the existence of claims that have been suspended or pended by JDHP, the reasons for suspending the claims, the number of suspended claims that are over 60 days old, and whether a potential material unrecorded liability exists. JDHP provided the examiners a pended claims report as of July 28, 2004. JDHP reported a total of 18,707 pended claims of which 235 were over 60 days old. The review of the pend file does not indicate a potential material unrecorded liability.

M. Electronic Claims Capability

Section 2-9.g. of the Contractor Risk Agreement states, "The CONTRACTOR shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment...." Section 2-2.h. of the Contractor Risk Agreement required MCOs to move to electronic billing. Electronic billing allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II ("HIPAA") requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

JDHP has implemented the changes necessary to process claims per the standards outlined in the HIPAA statutes. JDHP is currently processing claims under these standards for some of their providers.

N. Mailroom Testing and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures followed by JDHP ensure that all claims received from providers are either returned to providers where appropriate or processed by the claims processing system. The review of mailroom and claims inventory controls included observation of actual procedures. Mailroom and claims inventory controls were adequate.

Ten claims were selected from a batch of incoming mail on July 27, 2004, to determine if the claims were entered into the claims processing system with

correct received date. All ten claims were entered into the claims processing system with correct received date.

JDHP's claims inventory controls reconcile all claims received from providers. The claims are either returned to the provider where appropriate or processed by the claims processing system.

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

The purpose of testing provider complaints is to verify that JDHP responds to provider complaints in a timely manner.

JDHP's policy regarding provider complaints states that JDHP will respond to all provider complaints within 60 days. JDHP maintains a log of all provider complaints. To determine JDHP's compliance with its policies, examiners randomly selected 10 complaints from this log for the examination period.

The review of the 10 complaints revealed that JDHP responded with an acknowledgement of receipt of the complaint usually within 2 days. This response letter told providers that "Written notification will be sent to you with the decision reached as a result of our investigation within 45 days." Only one of the 10 complaints reviewed was completed and the provider notified of the decision within 45 days of the date of the acknowledgement letter.

Management's comments

JDHP concurs with the finding. We are maintaining our policy and process to complete provider complaints within 60 days. JDHP is no longer notifying providers that they would receive a response within 45 days.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. JDHP's current provider manual was reviewed and approved by the TennCare Division Compliance Section.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include, but are not limited to, standards of care, assurance of TennCare enrollees rights, compliance with all Federal and State laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the Contractor Risk Agreement between JDHP and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division of the Department of Commerce and Insurance in accordance with applicable statutes. Additionally, Section 2-18. of the Contractor Risk Agreement requires that all provider agreements executed by JDHP include the requirements listed in Section 2-18. of the Contractor Risk Agreement.

Three provider agreements related to claims selected for testing were reviewed to determine if they agreed to the approved provider template on file with TDCI. For two of the three agreements tested, JDHP had not updated contracts with the two providers based upon the approved provider templates.

The three provider agreements and the approved provider templates were then reviewed to determine if they contained the minimum language requirements of Section 2-18. of the Contractor Risk Agreement. All three agreements failed to meet the minimum language requirements of Section 2-18.

As of fieldwork, the following minimum language requirements are missing from two of the three provider agreements tested:

1. Section 2-18.oo. requires that "all provider agreements must include a provision which states that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare." The East Tennessee Hospital and Boys and Girls Pediatric agreements did not contain this language.

2. Section 2-18.pp. requires that the agreement must "specify that in the event that TENNCARE deems the MCO unable to timely process and reimburse claims and requires the MCO to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the MCO's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater." The East Tennessee Hospital and Boys and Girls Pediatric agreements did not contain this language.

As of fieldwork, the following minimum language requirements are missing from all three agreements tested and the approved provider template:

1. Section 2-18.ll., the language which requires that the contractor "shall ensure that providers have correct and adequate supply of public notices" was not present in the three agreements tested.

2. Section 2-18.qq. requires that "all primary care provider agreements shall specify that its network primary care providers shall submit all claims with a primary behavioral health diagnosis (ICD-9 CM 290.xx – 319.xx) to the CONTRACTOR for payment."

3. Section 2-18.rr. requires that "providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees." This language was absent from all three agreements tested.

Management Comments

JDHP concurs with the finding. JDHP had a template provider agreement approved by TDCI at the time of the exam that contained all the required language elements. We are currently utilizing this new template when executing any new contracts; however, we had not completed re-contracting all existing contracts due to the uncertainty in the TennCare program.

D. Subcontractors

During the examination period, JDHP had subcontracts in place with Davis Vision, Inc., for the provision of vision services, and Southland Health Services, LLC, (formerly Quality Transportation) for transportation services. The TennCare Division has not approved these contracts. Based on information obtained from the Insurance Division of TDCI, only the Davis Vision subcontract has been submitted to TDCI. This contract was an older version of the contract currently in use by JDHP. Agreements between an HMO and subcontractors represent operational documents to be prior

approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1).

Sections 2-9. and 2-17. of the Contractor Risk Agreement state that "all subcontracts and revisions thereto, as defined in Section 1-3 of this Agreement and described in Section 2-17. of this Agreement, shall be approved in advance by TENNCARE." Section 2-17. further states, "failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages or intermediate sanctions as described in Section 4-8 of this Agreement." JDHP had not complied with this section of the Contractor Risk Agreement.

Management Comments

JDHP concurs with the finding. At the time of the exam the Davis Vision, Inc. contract and amendment had been submitted to TDCI for approval. The Southland Heathland Services, LLC contract was pending approval from the TennCare Bureau prior to submitting to TDCI. Since the exam both subcontracts have been approved by TDCI.

E. Title VI

Effective July 1996, Section 2-25. of the Contractor Risk Agreement required JDHP to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various JDHP staff and a review of policies and related supporting documentation, JDHP was in compliance with the reporting requirements of Section 2-25. of the Contractor Risk Agreement.

F. Stabilization

Section 2-2.s. of Amendment 2 of JDHP's Contractor Risk Agreement requires JDHP to comply with the following:

> Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as that existed on April 16, 2002, unless otherwise directed or approved by TennCare, and to submit copies of all medical management policies and procedures in place as of April 16, 2002, to the State for the purpose of documenting medical management

> policies and procedures before final execution of this Amendment.

JDHP's management has confirmed compliance with the stabilization requirements. During testing of claims processing and provider contracts, no deviations to the stabilization requirements were noted by TDCI or the Comptroller.

G. Monitoring of Subcontractors

The Contractor Risk Agreement permits JDHP to subcontract duties but JDHP is ultimately responsible for ensuring that these duties are performed in compliance with the Contractor Risk Agreement and statutory requirements.

JDHP was able to document the procedures used to monitor and report results to its subcontractors. No discrepancies were noted in JDHP's process of monitoring subcontractors.

H. Interest

Section 2-9.e.5. of the Contractor Risk Agreement states the following:

> Interest generated from the deposit of funds for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the CONTRACTOR's bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

JDHP did not return any funds to TennCare for interest earned during the examination period. The deposits of state funds for provider payments are not retained in a separate bank account. The determination of interest generated from these funds is not readily available.

JDHP should develop a methodology to calculate the interest generated from deposits of TennCare funds since July 2002 and remit these amounts to the TennCare Bureau.

Management Comments

JDHP concurs with the finding, but does not agree with the recommendation that JDHP should develop a methodology to calculate the interest generated from deposits of TennCare funds and remit these amounts to the TennCare Bureau. JDHP generates checks weekly to reimburse providers for claims submitted. Each Tuesday checks are generated for the prior week's processed claims and then mailed. The TennCare Bureau is invoiced the following Monday and JDHP receives payment by the end of that week. This

payment is almost two weeks post check processing. JDHP is providing payment to the providers prior to invoicing and receiving payment from the TennCare Bureau and accordingly, we disagree that interest is owed or can be calculated. In fact, JDHP is providing the State the use of our money without an interest charge. JDHP believes strongly in providing prompt and efficient payment to providers for services rendered and that is why we provide payment prior to receiving funds from the TennCare Bureau. Changing this process would involve delaying payment to providers and require providers to receive and post multiple checks each week from JDHP since they currently receive only one check for all JDHP lines of business.

Rebuttal

As stated previously Section 2-9.e.5. of the Contractor Risk Agreement states that all interest generated from the deposit of funds for provider payments shall be the property of the State. JDHP and the TennCare Bureau should determine the appropriate method for compliance with this provision of the Contractor Risk Agreement agreed to by JDHP and this determination should be documented in writing.

I. Recovery Amounts/Third Party Liability

Section 3-10.h.2(f) of the Contractor Risk Agreement states third party liability recoveries and subrogation amounts related to the non-risk agreement period be reduced from medical reimbursement requests to the TennCare Bureau. JDHP reduced medical reimbursement requests to the TennCare Bureau for the amounts recovered from third party liabilities and subrogation.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of JDHP.